TRANSCRIPT REQUEST FORM

Belize Campus: Sea Star Drive San Pedro Town, Ambergris Caye, Belize

Phone: +1866.966.9843 / WhatsApp: +1440.732.5451 • Fax: +1614.340.4688 • Email: <u>registrar@wuhs.edu.bz</u>

Washington University of Health and Science

Please complete this form to request an official transcript from Washington University of Health and Science to be sent to the educational institution specified on this form. Transcript requests are normally processed within five to ten business days, however you may request expedited service. The completed form with the student's signature along with related fees may be submitted in person, by mail, by email or fax.

STUDENT INFORMATION

Full Legal Name	2:							
	Last/Family Name/Surname		First/Given/P	Personal	Middle			
Student ID Num	nber:	Current Enrollment:						
	As appears on ID card		Program - Semester					
Address:				()				
	Number and street or rural route		Apt. No.	Area Code	Phone Numbe			
		State	Country		Zip Code			
OUEST INFORMA	City or Town	State						
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l copies will be m edit/debit card a No. of Copies: Where would y <u>School's No</u>	ATION mailed to the address provided. uthorization. (Use separate for you like your transcript(s) to be a name:	The cost per transcript) Sa (le:			

FOR OFFICE USE ONLY

Date
Name
Remarks

Image: Image







ADDITIONAL INFORMATION

6 w	When would you like your transcripts to be mailed? (Check only one) Use a separate form for each request. Please be advised that transcripts may be ordered by, or released to, a third party only if written authorization is obtained from the student.							
	Mail Immediately; Mail when current term grades are available;							
] Mail when degree awarded;							
7 How would you like your transcript mailed? (Check only one) Use a separate form for each request. Please be advised that transcripts may be ordered by, or released to, a third party only if written authorization is obtained from the student.								
	Mail in US w/domestic tracking:		\$6.00					
	Mail with Expedited Service & Tracking:	U.S. Canada All Other International	\$40.00 \$60.00 Will be quoted					
	Receive In person on campus:		No Charge					
	Each Transcript Processing Fee (a separate form must be submitted for each agency to	o be mailed to)	\$40.00					
TOTAL DUE:								

INSTRUCTIONS & AUTHORIZATION

An official transcript will be sent from Washington University of Health and Science listing all credits earned upon the time indicated above. Official transcripts are for educational institution purposes only and are printed on high quality stock paper, containing the WUHS seal, and the signature of a certified school official.

- Transcript Requests must be reviewed and approved by the Office of the Registrar
- WUHS reserves the right to set criteria for transcript requests.
- There is a \$40 processing fee for each official transcript request. Must be paid at the time of transcript request by completing and submitting a Credit/Debit Card Authorization (see attached form).
- Fee payment and student signature are both required at time of ordering Official Transcript(s).

8 AUTHORIZATION: I am/was a student of Washington University of Health and Science and I hereby authorize the school to send my official transcript(s) to the educational institution specified in this form. I have read and understand the aforementioned instructions. I fully acknowledge that my official transcript(s) will only be released upon approval of this Transcript Request Form, duly filled and submitted along with the required fees. I understand transcript(s) will not be issued if my student file is not in "Good Financial Standing."

Student's Signature: _____

Date: ____/__ __ / _____

**submit completed form(s) to email address: registrar@wuhs.edu.bz





STUDENT INFORMATION

1	Student Name:								
		Last/Family Name,	/Surname		First/Given/P	Personal	Middle		
2	Student ID Number:		Cui	rrent Enro	ollment:				
		As appears on ID card			Pi	Program - Semester			
CA	RD OR ACCOUNT HOLDE	R INFORMATION							
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4	Address:					()		
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	City or	Town	Stat	е	Country		Zip Code		
	Credit Card Number								
	Expiration Date	Card Code* Card	Type: VISA		ER CARD		VER		
			L						
	ΜΜΥΥ	*three digit code on back of	of card						
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Effe	ctive May 1, 2012– credit/debit/ACH	I debit payments will be assessed o	a fee of 4% of the a	mount being (processed.				
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	Account Number		<u> </u>						
Authorized Amount (4% will be added) Card Holder email address:									
		(In US Dollars)							
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Bei	ng the cardholder, by signing bel	ow I understand and agree to	pay, and specific	ally authoriz	ze American Aca	demic Ser	vices and Technology to		

charge the credit/debit card account for the university services provided. I have received and accept the current charges applied to student's account. I further agree that when paying for this service and receiving the service requested, this payment is not eligible for chargeback and/or reversal of payment.

*By Signing, you authorize the above credit/debit/ACH debit transaction

Signature:

YOUR RECEIPT will reflect: American Academic Service and Technology

Date:_____